SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Group Application - Variable	SERFF Tr Num: SLIA-128088504	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H21.000 Health - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Stacy Patacsil	Disposition Date: 02/13/2012
	Date Submitted: 02/13/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 02/13/2012	
State Status Changed: 02/13/2012	Deemer Date:
Created By: Stacy Patacsil	Submitted By: Stacy Patacsil

Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:

Attached for your review and approval is a Variable Group Application, which will be used on a general basis when Employer Groups apply for all insurance coverage. This is a new form that would not replace any existing form. Please note that all bracketed text is intended to be variable and will be customized based on the product being offered. A Statement of Variability has been attached to explain all variable text.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Stacy Patacsil,
1808 Colonial Village Lane
Suite 102
Lancaster, PA 17601

spatacsil@securitylife.com
800-233-0307 [Phone] 5718 [Ext]

Filing Company Information

Security Life Insurance Company of America
10901 Red Circle Drive

Minnetonka, MN 55343-9137
(952) 544-2121 ext. 3589[Phone]

CoCode: 68721
Group Code: 492

Group Name:
FEIN Number: 41-0808596

State of Domicile: Minnesota
Company Type: Life, Accident & Health

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	$50.00	02/13/2012	56295586

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/13/2012	02/13/2012

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 02/13/2012
Implementation Date:
Status: Approved-Closed
HHS Status: Not Reported
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/13/2012	GROUPAPP.2011	Application/ Enrollment Form	Group Application	Initial		0.000	GROUPAPP.2011.pdf

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

[Marketing Name]

GROUP APPLICATION

PLEASE PRINT CLEARLY

General Information

Employer's Full Legal Name (exactly as it will appear in the Contract):

Coverages Requested (complete and attach an addendum for each coverage selected):

[❑ **Term Life]** [❑ **STD]** [❑ **LTD]** [❑ **Dental]** [❑ **Vision]**

Business is: ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other _____

State of Incorporation: _____

Tax ID Number:	**Years in Business:**
Nature of Business:	**SIC Code:**
[For groups with 2 to 9 eligible employees: Is this a home based business? ❑ Yes ❑ No]	**[For groups with 2 to 9 eligible employees: Are 90% or more of the employees in the same family?]** ❑ Yes ❑ No

Complete Street Address:

Street _____

City _____ State _____ Zip _____ County _____

Complete Mailing Address (if different):

Street _____

City _____ State _____ Zip _____ County _____

Contact Person: **Title:**

Email:	**Telephone Number:**	**Fax Number:**

Who should receive the initial Certificates and Administration Materials?

❑ Employer—***Email required:*** _____ ❑ Producing Agent

Type of Bill Requested: [❑ List Bill] [❑ Self-Administered **(Not available to groups <100 lives or groups applying for Dental or Vision)]**

Billing Frequency: [❑ Monthly] [❑ Quarterly] [**(Not available for Dental or Vision)]**

Easy-Pay Method (electronic transfer of premium)**:** ❑ Yes ❑ No **If Yes, then Form# [EZPAY2008] must be completed.**

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: ❑ No ❑ Yes; if Yes, complete the following:

Subsidiary Name: _____ **Complete Street Address:** _____ _____	**Nature of Business:** ❑ Same ❑ Other _____ **Number of employees** _____
Subsidiary Name: _____ **Complete Street Address:** _____ _____	**Nature of Business:** ❑ Same ❑ Other _____ **Number of employees** _____

[FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit, if false information materially related to a claim was provided by the applicant.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND WASHINGTON
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.]

Declarations

APPLICANT'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

_____	_____	_____
Signature of Officer or Owner	Print Name of Officer or Owner	Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

_____	_____	_____
Signature of Agent	Print Name of Agent	Date
Address:	Telephone #: Email:	License #:

HOME OFFICE USE:

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
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Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	02/13/2012
Bypass Reason:	Not applicable for this Application filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/13/2012
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	02/13/2012
Bypass Reason:	Not applicable for this application filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	02/13/2012
Bypass Reason:	Not applicable for this application filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	02/13/2012
Bypass Reason:	Not applicable for this application filing.		
Comments:			

SERFF Tracking Number:	*SLIA-128088504*	*State:*	*Arkansas*
Filing Company:	*Security Life Insurance Company of America*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Application - Variable*		
Project Name/Number:	*/*		

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability	Approved-Closed	02/13/2012

Comments:

Attachment:

Group Application SOV.pdf

Group Application – Statement of Variability

Section	Language	Variability
Heading	Marketing Name	Space available to insert the Marketing Name, i.e. FIVESTAR
General Information		
Coverage Requested	Term Life STD LTD Dental Vision	Coverages available will be listed
	For groups with 2 to 9 eligible employees: Is this a home based business? ❑ Yes ❑ No	Question will be included if the product is being sold to small groups.
	For groups with 2 to 9 eligible employees: Are 90% or more of the employees in the same family? Yes No	Question will be included if the product is being sold to small groups.
Type of Bill Requested	❑ List Bill ❑ Self-Administered **(Not available to groups <100 lives or groups applying for Dental or Vision)**	If the employer has an option, both will be listed, or one will automatically be shown.
Billing Frequency	❑ Monthly ❑ Quarterly	If the employer has an option, both will be listed, or one will automatically be shown.
	(Not available for Dental or Vision	Optional to Include, if applicable
Easy-Pay Method	Form #	Variable to update form number as needed
Fraud Statements	Fraud Language	Variable to remove non-applicable fraud language and to update as needed.
Footer	Address, Telephone, Web Address	Variable to update as needed